

Lara: Hi, everyone. We'll just get started in a few minutes. Good morning everyone, I guess we will get started. I know people are still registering and entering in the interest of being respectful of time. I want to get us going. So, good morning, good afternoon and good evening to everyone. My name is Lara Vaz. I'm the Deputy Director for MOMENTUM Knowledge Accelerator, and on behalf of them, Knowledge Accelerator team, I want to thank everyone for joining us today for this webinar, which presents the results of a rapid evidence summary on the effects of COVID-19 on essential maternal, newborn and child health and nutrition, family planning and reproductive health care, and the strategies and adaptations that are emerging in response. This evidence summary was produced by a team MOMENTUM Knowledge Accelerator, representing all three partners in the award. Population Reference Bureau, JSI and Ariadne Labs. Next slide please.

So in the webinar today, Meg Ivankovich will start by providing a short background to why the summary was carried out and present an overview of the evidence review findings, capturing the effects on essential health care. Lisa Hirschhorn will follow with an overview of the strategies and adaptations to existing health systems and emerging effects, and then summarize the evidence as well as present some exact suggested actions. We will then open up the webinar per discussion with the authors including Emily Stammer. During the presentation, you may place the questions in the Q&A box in the panel to the right of the presentation. I will facilitate the question and answer section. Our team also has some questions we'd like to pose to you. When we get there I will ask you to please use the raise hand option for you to participate.

And I will call on those people with raised hands to unmute themselves and turn on video if you would like. A few housekeeping notes before we get started. This webinar is being recorded. We will be sharing the full slide deck along with the annexes noted here shortly after the webinar. And importantly, we have a very brief survey at the end of this webinar, and we hope that you'll participate in it so that we make future webinars even better. The survey will launch as a web page in your browser at the end of the webinar. Please use the last minutes to complete the survey on the browser because we really would value your feedback. I am now turning the presentation over to Meg Ivankovich.

Meg Ivankovich: Great. Thank you so much Lara. Evidence suggests that disease outbreaks on the response to control... And the response to control them. It can have negative impacts on the demand for and provision of maternal newborn and child health, nutrition, voluntary family planning and reproductive health care. In order to maintain accessible quality coverage, we must understand the causes of disruptions to care as well as identify and implement strategies to prevent [inaudible], mitigate decreases when they occur and respond to drops already occurring. This is certainly true during the COVID-19 pandemic. So why did we conduct this evidence summary?

In March, we recognized the COVID-19 with having direct and indirect impacts on the provision of, and demand for quality care. Earlier this year, our team conducted a rapid evidence summary focused on the lessons from outbreaks of shocks, similar to COVID-19, such as Ebola, Zika and H1N1, as they relate to community and facility level of maternal newborn and child health, family planning and reproductive health care delivery and utilization. With the growing evidence based on COVID in the peer reviewed and grade literature, we set out to conduct a similar evidence summary, looking at the impact of, and responses emerging from the COVID-19 pandemic, specifically in lower and middle income countries.

This work was intended to inform USAID program planning and uncover gaps that needed to be addressed during and after the pandemic. Our evidence summary [inaudible] to answer two questions. First, we wanted to know how COVID-19 and responses to it affected the provision of and demand for care and related health and wellbeing. Secondly, we were interested in learning what strategies were being adopted and what adaptations made to existing health systems and what was their impact on accessible quality care. Our search strategy reflected the earlier work and learning from the first evidence summary. But we took a more inclusive approach with this search, given the fluidity of the situation.

While many peer reviewed publications are prioritizing COVID related literature, much of the most up-to-date information is being shared through sources, not traditionally searched for literature reviews, including websites, blogs and webinars. Therefore, we opted to include both traditional and non-traditional sources for relevant evidence. Sources that focus on outcomes related to maternal newborn and child health, nutrition, family planning and reproductive health in low and middle income countries that were published after April 1st and in English were included. More information about our methodology can be found in annex one of this slide deck, which we will share after the presentation. Our search resulted in 22 articles and 17 reports, websites and webinars. Most studies were retrospective and observational, but 18 intervention studies were also included. We found the most evidence of effects from country-based informants, such as those gathered through canned form in interviews and webinars with country-level representation, as well as HMIS data and internet surveys. As you can see from the heat map, most countries represented were in Asia and Sub-Saharan Africa with only one resource from Latin America included. Over half of the resources included data from USAID priority MCH or PRH countries,

When considering the area of focus covered by our sources, articles commonly focused on maternal health outcomes, such as facility-based delivery and antenatal care. In addition, they looked at family planning, newborn health, child health and immunizations, and to a lesser extent, gender based violence and nutrition. Some sources looked at health system strengthening in general, which we included given their indirect impact on health care and health

outcomes. Several studies had a dual focus on other health topics, including mental health, HIV, water and sanitation, and other essential health care. The complete list of sources included in this rapid evidence summary can be found in the bibliography presented in annex three of the slide deck.

The next two slides present a summary of the effects of COVID on the provision of and demand for care and health and wellbeing uncovered in the evidence. Please note that more detailed findings are presented in annex two of this slide deck. Most sources reported disruptions in most essential care. It's important to note that many studies that presented a reduction in patients accessing care did not clearly distinguish whether those changes were a result of changes in service provision or demand for care. As expected, the evidence shows that the COVID-19 pandemic and resulting response have impacted human resources across reproductive, maternal newborn and child health care. There have been reductions in the number of health workers due to infection and deaths due to COVID as well as reassignments for the COVID-19 response in country. Providers in some countries also report a general lack of training and support.

In Nepal and Malawi for example, health workers reported feeling confused due to change in guidelines regarding the provision of care in the context of COVID. In one study, 90% of maternal and child health providers globally reported feeling an increase in stress due to a variety of factors, including fear of illness, exhaustion and lack of compensation or appreciation. In some cases they're seen as a threat to the safety of their families and communities, which has led to stigma, rumors and even violence targeted at healthcare workers. The costs of sustaining care have increased due to the additional costs of responding to COVID, including purchasing PPE and additional supplies and arranging for isolation capacity.

In addition, some facilities have limited the provision of care to only the most urgent cases. In Ghana and Zimbabwe for example, immunization campaigns and community-based outreach had been postponed due to COVID. The pandemic has also caused a deterioration in data monitoring and reduced reporting rates in some countries. We've also seen travel restrictions affecting international freight movements and reduced production in essential products due to supply and workforce challenges. This has led to stock outs or shortages of key products such as drugs PPE and other essential medicines.

The evidence also report the shifts in care seeking behaviors, attitudes and practices. Clients in many countries have reported perceiving it to be riskier to seek care at health facilities due to fear of being infected. This has resulted in shifts of care seeking from health facilities to community-based care, which was also seen in the previous summary of effects of Ebola. In South Africa, Kenya and India for example, there's been a shift away from long acting reversible methods of contraception to short acting and often less effective methods. Some countries are also reporting decreases in patients' use of short term

methods. The literature on the impact of COVID on health outcomes is nascent but growing.

For example, higher levels of anxiety and depression for pregnant women and mothers were seen in Turkey, Bangladesh and China. Researchers in Malawi and Kenya reported an increase in adolescent pregnancy. Regarding newborn health rates of institutional stillbirths increased in Nepal and Kenya and neonatal mortality increased in Nepal. Increases in rates of gender-based violence were reported in Somalia, Zimbabwe and Bangladesh and making matters worse reported closures of health facilities in response to COVID-19 are contributing to a reduced accessibility of sexual and gender based violence care. This is particularly concerning for cases that require timely access to post rape treatment. I now welcome my colleague Lisa to report on findings related to our second guiding question, looking at promising strategies and adaptations being implemented during the COVID response.

Lisa Hirschhorn:

Great, thank you so much Meg. And again, thank you everybody for coming. So we try to really look at these at the different levels that we thought were going to be absolutely critical for identifying what might be some of these strategies. And the first one that we talked about was sort of national policy adaptations. And so this includes, for example, this development and dissemination of protocols for the provision of RMNCH healthcare during the pandemic often with tweaks to how this was being done for example from Ghana or Bangladesh. Sort of more of an advocacy as well as policy, which was really designating that these services, these healthcare was essential to promote the continuity of care similarly and quite in, in contrast to what we saw for Ebola, but also allowing for advocacy efforts during lockdown, for example for women in labor.

Improved coordination integration and critically importantly stakeholder and institutional alignment in terms of what they were doing, this is Bangladesh had some very good examples. And then the use of data for very rapid and dynamic policy decision-Making really seeing this emerging adaptive learning. So for example, immunization targeting placement of staffs and influencing some of the lockdown policies for example, from Uganda. Next slide.

Now these adaptations were just at the national level, but also went down to much more local at the facility level for strategies and adaptation. I think one of the most important things that we saw was the recognition of the need for COVID-19 risk reduction within the context of the facility, social distancing, provision of PPE, promotion of infection prevention control measures in facilities. We saw this across many, many different countries. In addition, there was really a focus on not just protecting the health care worker, but also supporting them in delivering care. I think there's been rising as been noted in reports of stress. And so the recognition of support for healthcare workers that we saw, for example in a number of different countries, such as in Malawi, but also more frequent communications for patient management in Ghana, and then capacity building in Malawi, so that they weren't ignoring the fact that

even during the pandemic, people still needed support and ongoing training and supervision for quality for the required care. Next slide please.

Now it was also very exciting to see some of the technological adaptations at the district or facility level. And these are examples where it's actually been found to be very helpful. For example, triage and referral has been used in Uganda and Ghana and South Africa. Some really innovative things about using request for transportation to facilities. That's been used for example, in Uganda, as well as remote monitoring and follow up, that's been done to really continue to keep people in care. There was some interesting use of hotlines would provide information about care options and where to seek care, to recognize the drop in supply when demand was still there. And again, this focus on ongoing training and learning and supervision to ensure that there was support to continue to provide quality care and then some really great use of commodity delivery for example, drones in Ghana which is building on some of the experience that has been seen in some other countries in the pre-COVID era. Next slide please.

It's also been very well recognized by these countries of the potential for community-based care, but also other community focused strategies. Again, reflecting back on this idea of the need for emergency transport this increased focus on using and coordinating with the local existing community emergency transport systems in Ghana, as well as in Uganda, but also in recognizing that there're needs to be this outreach to combat fears with community mobilization and advocacy efforts tools such as we see on the right, promoting a home-based anti-natal care by community health workers being done with COVID-19 precautions. And there's other examples of this as well. And then I think importantly sort of looking at what have we learned from the previous pandemics. So for example in Ebola to proactively do some increased outreach to help prevent the teenage pregnancy spikes that were seen in Ebola. Next slide.

Now, one of the things that was very clear is that there's no single strategy that's going to be able to do this. And we're just giving two examples where we see these multi-pronged strategies that are being used, for example, in Ghana to improve maternal health care. We saw at the policy and system level, again, the development and dissemination of guidelines of all regions and strengthening of triaged at emergency obstetric and newborn care facilities, but also then this innovation use of mHealth for deployment of information technology for learning and supervision, what's that platforms connecting facilities and other types of ways that providers could actually talk to each other to ensure continuity and then as discussed the use of drones for emergency, MNH supplies and as well as COVID-19 sample. So to increase the testing and then also with the facility and community adaptations, reorganization of health care delivery this ongoing really emphasis on improving quality, so audit and feedback for learning, and then also this increased coordination emergency referrals, again, including the use of the community emergency transport. So we

see here multiple strategies, each of which is responding to a potential bottleneck. Next slide please.

In Bangladesh, we also saw that they had multiple different adaptations that were being done. And in this, we're actually beginning to see some hopeful evidence that the adaptations may indeed be helping immunization coverage rebound. I realized that textures is quite small, but there's issues around guidelines and intensify of monitoring to be able to understand who is not be... Who's falling off and then an emphasis on the listing and the interventions for the people who were actually dropping out and immediate vaccination, almost a new way of using impanelment. Thank you. Next slide.

Now, some of these solutions actually went well beyond the facility level, but also we're looking more broadly at health system solutions. One of the things that we've heard that was very important was this close collaboration between essential care and COVID-19 teams so that they weren't acting in conflict to each other, identify priorities, restructuring care to both accommodate COVID prevention, but also ongoing care. Again, this health product delivery changes, which included not just the delivery by drones, but issues around rerouting shipments, changing modes of transport for delivery, shipping to neighboring countries who were having stock-outs as well as exploring some road transport and air charter options. Production itself, there's a recognition that there needed to be some changes.

So, local sourcing options, alternative solutions linkage to new markets. So really a lot of innovation that was happening with that, as well as introduction of new analytic tools to help people with some of their supply chain management. And then very importantly recognition of the absolute need to involve the private sector, as well as non health departments to increase the management capacity for the health system. And so drawing on expertise where it was available in a multi-sectoral approach. Next slide, please.

So what did we find just in general? What we found was rapidly emerging evidence of the effects on the provision of an [inaudible] for MNCHN, family planning reproductive health care. This was really from a wide variety of places that were being reported, canned form in interviews, quantitative surveys, HMIS data, similar to prior outcome outbreaks, we are continuing to see robust evidence on the negative impact on the provision of, and the demand for this care. But the potential for large scale harm could still be prevented. While there is less data on the strategies used to lessen or respond to drops in care, provision, and demand and their impact. And we are beginning to see some really exciting lessons that are being shared. Next slide.

Now, we also found that, again, that there's not a single strategy that's going to be effective, but that countries are employing multiple strategies, addressing different levels and factors that are associated with these challenges. And there are a number of strategies, however, that are worth exploring or considering for

spread, which include changes in how the health care is delivered, effective protection and management of health workers, whether in the facility or in the community, engaging the effected communities in decision-making to maintain or to strengthen trust in health system. A very important lesson from Ebola. Ensuring the safety of, and the confidence in healthcare, again, for the healthcare workers and for the community. And finally harmonizing efforts of the partners, the national and initiatives and donors for more efficient and effective response. And making sure that we're measuring not just access, but access, quality, equity, and identification of these emerging solutions and the mechanisms for spread. Next slide.

Now despite enormous work done by the team and really sort of shout out to Emily and Meg for this, we really found that there was very little publicly available evidence on the impact of strategies and adaptations. And where data were available, it was often hard to determine the relative contribution. This is not a place people are going to be doing randomized control trials. But where the sort of where the challenge was the choice of the strategy of the implementation, the influential contextual factors and other actions. And as this pandemic has continued to evolve, we've not really found much evidence on tailoring these adaptations to different phases of the pandemic. There was very limited insights into the quality of data presented, and many of the studies had quite weak study designs. And very little mention was found to date of the private health sector, as well as from the fraudulent and conflict affected settings. Although we're hopeful that that will continue to emerge. And it's very important to recognize these limitations indicated need to strengthen data collection, measurement and analysis and use of the community national and facility level. Next slide.

So how can we contribute in order to better learn and translate evidence into action? This is really a concept that we've been really working on hard about these sort of three different triangles that we need to prevent the disruptions mitigate the factors and respond. And to do this, we need to support improved documentation and sharing of the adaptations and strategies and their effects, and really get a deeper understanding through applying adaptive learning, implementation research and context aware monitoring so that we can understand what are the contexts, what are the results, and can really therefore provide support to help inform strategy choice adaptation implementation in different settings and at different points of time, and very critically to help translate this emerging evidence into action. Next slide.

This is just a number of the useful sources of information that we have. It's always continuing to emerge. And just some of the places that we've found to be particularly helpful. Next slide. And so I'm just... I'm going to hand this over now to Lara.

Lara: Great. Thank you very much Lisa and Meg for that wonderful presentation and overview of our findings. More details of the findings as mentioned are in the

annexes by country and with the full bibliography. We will be sharing those at the end of... After the webinar. I'm hoping to open this up for some discussion and comments. So, first of all, are there any questions? I don't see any in the box yet? So if you have any questions, if you could please type them in o the box labeled questions.

Meg Ivankovich: Lara, if people are sending in their questions, I did just want to note that we will be coming out with a complimentary policy brief, as well as annotated bibliography based on the findings uncovered in this rapid evidence summary. So we will be sure to share that with any interested attendees.

Lara: Yes. Thank you. And also to note that both the policy brief and the annotated bibliography will be up on the MOMENTUM website, so we will share those out to participants, but we will also post them on the website. Thank you for that reminder. There are no questions. We do have some questions for you our audience, because you yourselves are our sources of information. And so my question to the audience, and we're going to request hands to be raised if people want to chime in, are about the strategies that you have seen in the last few months to address reported drops in the provision of, or demand for care. So what strategies have you seen? What evidence of success has emerged from those strategies? Everybody should have been unmuted. So ,if you are interested in responding, we would really love to hear what you are seeing in out of the countries that you're supporting right now.

Shawn: Hi, Lara, this is Shawn.[inaudible] I don't have an answer for that question, but I did want to let you know that I sent in a question too through the chat. But [crosstalk] so that's interesting that you're not seeing it. Because there might be other questions that are coming in that you're not seeing. Well, I can tell you what my question was. I just wanted to hear a little bit more about Lisa mentioned the strategies to engage the private sector. And then I heard you also say that there was very little description of those strategies, but I wonder if you could just say just a little bit more about if you have any more information on how countries are working with the private sector in different ways.

Lisa Hirschhorn: I can take a little bit of a first response to that. And so this was... Interestingly, this was more about management capacity, again a core competency that's often ignored when we talk about health care. And it was within South Africa involving private sector and non-health departments. Emily and Meg could probably talk a little bit more about the fact that while we saw a little bit of that given what we know about the growing role and often robust private sector in a number of these countries. There was not much that was being available. Doesn't mean there wasn't things happening, but it could also be that the private sector may be less prone to be publishing or putting it out there in the various places that we were looking. But Megan, Emily?

Meg Ivankovich: [inaudible] Again, don't have too much more to expand on this, but as noted, we did come across very few articles as well as grey literature related to the

private sector. Much of the information that we were able to glean came from world publication from the world bank. So, clearly we're seeing more mention of the private sector contributions to the COVID-19 response in the grey literature. So also, just to note, we collected data up between April 1st and September 30th. But really towards the end of that period is when a lot of the literature was being released, both in the peer reviewed literature and additionally more grey literature. So, we certainly missed some really important pieces that came out in the past month or two. And Emily, if you want to... It's happy to hear your thoughts, if you have any more.

Emily: [inaudible] that's what I was going to say as well. It's just that there was definitely limited information on private sector.

Lara: Lisa, we have a question from Troy Jacobs. He is asking, can Lisa talk at all about costs of doing business differently, lessons learned or area for future exploration? The economics have changed and we assume it has increased, but it seems like a lot of unknowns.

Lisa Hirschhorn: Yes. I think that's a really, really important point. And I have to say, even in things like implementation research, it's an area that's often nobody wants to actually talk about. But clearly there is emerging evidence on increased cost and it's not just the PPE. That's obviously there, but also the cost of other supplies as well as for people that are getting, for example, top sort of additional pay for overtime or for other work as people are having to do both COVID as well as other work. And then thinking about some of the other ways that people have had to shift where, for example, more outreach for vaccination. I've seen qualitative information. I don't know that I've actually seen it costed out. Again, will sort of defer to Emily and and Meg on that, but I think a very, very important thing because it does impact sort of what the countries actually need to continue to have a robust effort to maintain these absolutely critical care.

Emily: Yes, I would agree that there wasn't much that we found related to cost in the literature that we came across. But from some other work being done it does... And sort of emerging information. It does sound like there has been quite a shift in some budgets toward the COVID-19 response and sometimes away from SRH commodities and services. So it'll definitely be something that we should keep on our radar to look at in the future.

Lara: Yes. Thank you Emily and Lisa, I think a couple of other things, I know that from what I saw, I've seen there's the cost of doing business differently. Certainly like the additional PPE costs for workers providing essential services has been noted. But the actual cost has not. I do think it'll be interesting also to see what our colleagues through MOMENTUM in country and global leadership are producing. They are doing some work around infection prevention and control and in facilities. And some of that may actually have some costs attached to it. I know in the past they have attached some costs to that work. So I think the

MOMENTUM suite will certainly be producing some of that information themselves.

I don't see any other questions, but we have lots of questions for you. Again, if there are, who are willing to share about the strategies that you've seen in your countries to address drops in provision of or demand for services, that would be great. We also have a question about the kinds of data that your countries are using for monitoring care availability in uptake. And is there any experience that's emerging about which indicators seem to be most useful? Is there any evidence that is being generated that is being shared around that and where could it be shared or should it be shared? And that also includes the efforts to measure changes in the access. Checking to see if anybody's got hands raised. No hands raised. Is anybody seen anything around the private sector?

It's an area where we have limited information to date, but I think some of our participants are working in countries where there are different private sectors and private sector engagement. Are people actually seeking care from private sectors or shifting care seeking from public to private? Or is it the other way around? Or are we seeing drops all around? Huh, hand raised. Barbara?

Barbara: Hi everyone.

Lara: Barbara?

Barbara: Hi, everyone. Good morning. Listen, I wondered if in your scan or whether any of the individuals on the call, I have examples of where temporary changes in policy have been introduced for example, giving greater latitude to community health workers to provide certain kinds of contraceptive methods. Because again, this is I guess the opportunity with COVID-19 is that temporary measures may be introduced that would relax some of the restrictions that affect access to contraceptive methods. And some of those temporary measures might in turn stay in place after the pandemic is settled. Over.

Lara: Thanks, Barbara. That's a great additional question. So in addition to the questions we have around emerging private sector, experience also anything around temporary policy measures, that may have been introduced. Yolanda Oliveros I saw your hand raised and it went back down. If you still have something to contribute, please go ahead.

Yolanda Olivero...: Yes. Hi there. Good morning [inaudible] good evening to some of our colleagues. Yes. And [inaudible] of health. Can you hear me?

Lara: Yes.

Yolanda Olivero...: Okay. So I just want to share some of the strategies that we did although in small scale, in terms of engaging private sector. So, since the public facilities are now more devoted to addressing COVID pandemic. So, even the primary

facilities shifted their tasks to face contact tracing, risk communication. So the private sector, especially the midwives clinics came in and take on some of these essential health services that the public sector has been missing. Precisely because number one, since the people knows that the public sector is more catering on COVID and there are really some shortage in terms of human resources, many of these clients go to private provider clinics. So that's one. And so there's this and based on our rapid assessment to those private clinics providing service... Well delivery of babies and family planning services, they said that during COVID their clients increase the 30%, because many goes to the... To this [inaudible]. Another thing is the application of digital service.

So in one of the USAID support and activities, they also engage the Integrated Midwives Association of the Philippines. And with that engagement, many of the members of these Integrated Midwives Association who owns private clinics participated, and they did a tele-consultation and they also pulled resources so that they can have... They can procure commodities using the economy of scale. And they also partner with local courier so that it can be delivered to the other clinics or delivered to the patient themselves. So, that's just one example in private sector participation for service delivery. We also have a good experience on private sector participation when it comes to commodities like for example BKP, which is a big franchising distributor of commodities in the Philippines, they partnered with USA and in a delivery of our hygiene kits to the beneficiaries and in community isolation facilities, they provided some condoms and some contraceptives incorporated in the hygiene kits.

And on the question on... And then we also have Procter & Gamble Philippines who is also partnering with us to provide some of these essential hygiene materials and supplies to our my mother's maternal child health and family planning clients. For the community health workers, well there has been a shift because in the past our community volunteer or village volunteer workers were not allowed to do resupply of commodities, but now they were trained and now they are allowed to do resupply of commodities to current users. So at least there was that policy adaptation on the... So that the services will still continue, over.

Lara: Wonderful, thank you Yolanda. That was really very rich and it's actually very interesting to hear about the shifts and the gaps in coverage that the private sector is filling as the public sector is focusing more on contact tracing for COVID-19 as well as some really interesting private partnerships and the integration of care.

Yolanda Olivero...: I'd be interested actually in knowing whether those shifts in care seeking are being captured by data. Are the private midwife clinics reporting to the national [inaudible]?

Emily: Yes.

Lisa Hirschhorn: Yes.

Meg Ivankovich: Yes.

Yolanda Olivero...: So because that's really very important. So we make sure that those private[inaudible] engage are also trained and reporting their recovery service coverage through the public health information[inaudible].

Lara: It's really wonderful. Thank you very much. Are there any other questions or comments so far? We have questions opened about interesting strategies, the role of the private sector. Yolanda has given us some really interesting stories from the Philippines around some partnerships as well as how the data are actually being captured of these shifts in care seeking. Any other countries who would be interested in sharing some of what they're experiencing. Barbara's question also remains open as to whether there are temporary policy that have been implemented that might have longterm impact. I'm wondering if people have any recommendations on what ought to be done. And that includes in terms of what ought not to be done based on the experiences, but also on the kinds of evidence that need to be captured that might enhance our understanding. Please either raise your hand or jump in.

Emily: Lara, this is Emily. I just... I wanted to make one point about the community health workers and community health systems through some of the work that's being done through the reproductive health supplies coalition. We're doing some interviews with four different countries Kenya being one of them. And we did hear from Kenya that there also has been a shift particularly given fears with accessing family planning commodities through facilities due to the fear of contracting COVID that the community health workers have seen a greater uptick in particularly in the short term methods that they provide and none of this been published yet, but I just thought it was interesting. I mean... And hopefully that will be something that we can that we can get data on to triangulate in addition to the interviews. But through some of the community health information systems or C Stock some of the commodity information systems that we have in the country, but just another kind of example of what's happening at the community level.

Lara: Wonderful. Thank you, Emily. We do have a couple of questions. [inaudible] Has a question. And first of all, thanks for the interesting presentations and with limitations to social gathering and travel and movement, demand sides interventions, such as community level meetings and dialogues and household visits have been greatly impacted. And there have been shifts made to mass media and digital channels. [inaudible] is wondering what interesting adaptations to interpersonal communication type activities beyond the motorized campaigns the team has found. Opening it up to the team. And I would actually request [inaudible] to please after the response to please add some information, because I think that you may have some more information to share. Team?

Lisa Hirschhorn: I can... And I apologize some of this is I think, from the review and some of it is having gone to many of the webinars that sort of tends to blend a little bit. So apologies if some of this is coming more from webinars. But we've seen some interesting work, for example, going back to the old fashioned radio in terms of trying to get messages out from trusted voices similarly, a part of some work to whether permitting to be able to leverage the ability for both social distancing, as well as outdoor spaces and then some of the no touch protocols that which some of the community health workers may be using to continue to do outreach, but not actually entering the house.

And recognizing the transmission risks, which are significantly reduced by use of PPE as well as by distancing and being outdoors. So I think people are being very creative about using that. I think some of it depends on what are the common and trusted modes of communication, whether it's person to person, whether it's by leaders, whether it's through social media or texting or other reasons. So, I think there's been an enormous amount of creativity. I personally have not seen much in the way of whether this is actually changing attitudes, but I'd refer to Megan and Emily for other insights.

Lara: Thank you, Lisa. Yes, I'd be really interested. I haven't seen as much of the evidence of the effectiveness of the shifts or the impacts of the shifts, but I think that would be really interesting for us to be capturing. [inaudible] Have you seen anything around that within your context?

Speaker 9: Can you hear me it's afternoon for me here?

Lara: Yes.

Speaker 9: Okay. So, thank you very much for the presentations again, and really appreciate the response as well. So, I guess the shifts, just like you said have been typically before the pandemic, everyone there was always a mix of strategies, right? So multiple channels, which not so people, the surround sound effect. But I guess for certain behaviors, we do know that interpersonal communication approaches are probably more effective than mass media. But with the pandemic, we sort of had to shift to the impersonal modes of communication. And I guess just like you did say for the interpersonal ones the few innovations here and there, but I was hoping maybe there might be things outside of the box thinking that maybe has happened in other countries that we might be able to learn from.

So the motorized campaigns was one where people move around streets with megaphones and continue to have those discussions from a distance. I think one thing that we also saw were maybe the need to do a risk assessment. So, there were intentional efforts that looking at communities that had active community transmission versus those that didn't, on screening even the community volunteer themselves to make sure that they were not a risk to communities or that the communities were not a risk to them. So there were all those efforts as

well, in terms of just coming up with tools and things that people could use to minimize risk. That's an addition to wearing PPEs of course, and all of that. So there were a couple of those interests in things and limiting the number of people and community events, outdoor, making sure they wash their hands before they come in, social distancing when they sit down and stuff like that. I mean, it was just... It would use as the scale at which you can go at the community level and somewhat increases the cost as well.

So, because now you have to think about PPEs and think about all of the facilities for hand washing that may not have existed and all of that. So it's a mix, but that's just about the kinds of things I've seen at the interpersonal level. So, thank you.

Lara: Thank you. I also want to note from our colleague [inaudible] USAID West Africa, that he has noted that USAID West Africa has commissioned a four country assessment. That includes a Burkina Faso[inaudible] Togo on the impact of COVID-19 on family planning. And the assessment has both quantitative as well as qualitative data including trend data around access before, during and after and policy maker interviews. The report is delayed and available soon. [inaudible]do you want to actually provide some additional information? I know you are having some audio problems. If you are able to provide a little more information, that'd be fantastic. Okay. I understand. Unable to talk.

But we would very much look forward to having to being able to see that report. I also know that USAID has been having one frequent lessons from the field. I understand that some of those documents are being collated and curated and will be accessible to the USA teams. I think that would be really useful to be able to learn not just what's happening within a country, but perhaps learning about things that might be adaptable across borders and dependent on the context and understanding the context in which these things are taking place. We are drawing to a close and I want to thank everybody for joining us today. And I'm going to hand this over to Shawn to close this out.

Shawn: Thanks Lara. And I'm going to make this very quick. I just want to thank all the panelists and the entire MKA team for all their work in pulling this together very quickly. It was a huge amount of work and very helpful, so much appreciated. I also want to remind people that there's a quick survey for you to take. We've greatly appreciate if you could take a few minutes, this will really help for informing future webinars. So, have a wonderful day, evening and everyone take care. Thanks.

Lara: Thank you Shawn.

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